STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/21/2011

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RIVERBEND	2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN47130

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R0000	This visit was for a State Licensure Survey. This visit included the Investigation of Complaint IN00092933. Complaint IN00092933 - Substantiated. No deficiencies related to the allegations are cited. Survey Dates: July 18, 19, 20, and 21, 2011 Facility Number: 010885 Provider Number: 010885 AIM Number: N/A Survey Team: Gloria J. Reisert, MSW, TC Dorothy Navetta, RN Donna Groan, RN (7/20/2011) Avona Connell, RN (7/20/2011) Census Bed Type: 106 Residential 106 Total Census Payor Type: 106 Other 106 Total Sample: 07 Supplemental Sample: 19	R0000	The creation and submission of this Plan of Correction does not constitute an admisison by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These State Residential findings are cited in accordance with 410 IAC 16.2-5. Quality review 7/26/11 by Suzanne Williams, RN			
R0036	(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interviews, the facility failed to notify the physician when physical therapy evaluations had not been completed as ordered for 1 of 1 resident in a sample of 7 residents and 1 of 19 residents in a supplemental sample of 19 residents reviewed for therapy. (Residents #4 and #13) Findings include: 1. Review of the clinical record for Resident #4 on 7/19/2011 at 10:50 a.m., indicated the resident was admitted on 7/14/2010 and had diagnoses which included, but were not limited to, seizures and chronic back pain. On 4/29/2011, a new physician's order for "Eval [evaluation] by PT [physical therapy]" was noted due to weakness. Documentation was lacking of the	R0036	It is the practice of this provider to ensure the physician is notified when a physical therapy evaluation has not been completed. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice *The facility notified the physicians of residents #4 and #13 that the physical therapy evaluations had not been completed and any new orders received, were noted. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. *All residents charts were audited for physical therapy evaluations to assure they had been carried out. *No additional resident charts were found to be out of compliance. What measures will be put into place or what systematic changes will you make to ensure that the deficient	08/21/2011

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	evaluation having been completed. During an interview with the Clinical Director on 7/20/2011 at 12:45 p.m., she indicated she had contacted the home health agency who was providing services to the resident and they indicated they had no record of an order for a physical therapy evaluation. She also indicated the physician had not been notified the physical therapy evaluation was not completed as ordered. 2. Review of the clinical record for Resident #13 on 7/19/2011 at 2:00 p.m., indicated the resident had diagnoses which included, but were not limited to, dementia and osteoporosis. On 5/24/2011, the Hospice physician wrote an order for "PT eval for use of walker, gait training, balance and strength." Documentation was lacking of the evaluation having been completed. During an interview with the Clinical Director on 7/20/2011 at 12:45 p.m., she indicated "the resident's family did not want anything done, so no PT eval was completed." She also indicated the physician had not been notified the physical therapy evaluation was not completed as ordered nor was he made aware of the family's request for no		practice does not recur. *The Clinical Director will audit all resident charts, that have new physical therapy orders for evaluations, to ensure they have been carried out and initiated.*All Nurses and QMA will be inserviced regarding facility policy on notifying the physician when orders for physical therapy evaluations are not completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place *The Clinical Director will audit, ongoing, all resident charts, that have new physical therapy orders for evaluations, to ensure they have been carried out and initiated. This will be completed within 48 hours of receiving the order for the physical therapy evaluation.	

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	further treatment or services.			
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interviews, the facility failed to complete new Pre-Admission assessments for residents prior to return from extended stays on the psychiatric hospital unit (Resident #14) or a rehabilitation unit in a long term care facility (Residents #4, 10, 11). This affected 3 of 19 residents in a supplemental sample of 19 and 1 of 7 residents in a sample of 7 residents reviewed for hospitalizations and extended care facility stays. Findings include: 1. Review of the clinical record for Resident #4 on 7/19/2011 at 10:50 a.m., indicated the resident was re-admitted to the facility on 6/16/2011 and had diagnoses which included, but were not limited to, seizures, anemia and back pain. On 5/13/2011, the resident was sent to the hospital due to weakness, weight loss, and	R0214	It is the practice of this provider to ensure an evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the residents condition, or more often at the resident's or facilities request. A licensed nurse shall evaluate the nursing needs of the resident. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. *Residents #14, 4, and 11 all had new assessments completed by the Clinical Director. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. *All residents, who had been out of the building for an extended stay or in a rehabilitation unit in a long term care facility, charts were audited to ensure an current evaluation was completed. The evaluation was completed by the Clinical Director. What measures will be put into place or	08/21/2011

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	not eating. The resident was subsequently transferred to an extended care facility for rehabilitation until 6/16/2011 when he returned to his apartment in residential care - one month later. Documentation was lacking of a new Pre-Admission assessment having been completed by a licensed nurse to ensure the resident remained appropriate for residential care living. During an interview with the Administrator and the Clinical Director on 7/19/2011 at 3:00 p.m. and on 7/20/2011 at 1:30 p.m., they indicated they were not doing new Pre-admission assessments by a licensed nurse prior to a resident returning back to the facility since they were already an established resident. They considered it the resident just returning to their apartment. The Administrator indicated the Leasing Manager who was not a licensed nurse, was the one going out to see the resident when he/she was ready to return and then she would come back and tell them about it. She did indicate that occasionally the Clinical Director did go out with the Leasing Manager, but that it was primarily only the Leasing Director and that the Leasing Director had been doing so for years. The Administrator indicated that a return		what systematic changes will you make to ensure that the deficient practice does not recur. * All residents who have been out of the building for an extended stay or in a rehabilitation unit in a long term care facility, will have new assessments completed prior to returning. *The Clinical Director will be inserviced on the facilities policy regarding new pre-admission assessments for residents prior to return from extended stays in the hospital or from a rehabilitation unit in a long term care facility. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place *The Clinical Director will audit, monthly, ongoing, all resident charts that pertain to those residents who have out of the building for an extended stay or in a rehabilitation unit in a long term care facility, to ensure a new assessment was completed prior to re-admission.	

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	from an extended care facility was no different from a return from the hospital and that since no new Pre-admission assessments had been completed on those coming back from the hospital, none were being completed on the extended care facility stays either. 2. Review of the clinical record for Resident #10 on 7/19/2011 at 9:47 a.m., indicated the resident was admitted to the facility on 3/27/2011 and had diagnoses which included, but were not limited to, syncope, hypertension, status post dehydration, and history of congestive heart failure. Documentation was lacking of a Pre-Admission assessment having been completed by a licensed nurse to ensure the resident was appropriate for residential care living. 3. Review of the clinical record for Resident #14 on 7/20/2011 at 9:35 a.m., indicated the resident was re-admitted from an extended stay at a psychiatric unit on 5/2/2011 and again on 5/25/2011 and had diagnoses which included, but were not limited to, dementia - Alzheimer type and depression. On 4/14/2011, the resident was sent to an -in-patient psychiatric unit due to an			

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	increase in physical aggressive behavior with exit-seeking behavior. On 5/2/2011, the resident returned to the facility after a stay of 19 days. On 5/14/2011, the resident was again transferred back out to the in-patient psychiatric hospital due to belligerent/disruptive behaviors along with exit-seeking for an extended stay of 12 days. Documentation was lacking of new Pre-Admission assessments having been completed by a licensed nurse to ensure the resident remained appropriate for residential care living. 4. On 7/19/ 2011 at 11:02 a.m., review of Resident #11's record indicated diagnoses included, but were not limited to, status post fall, hypertension, macular degeneration. Review of the nursing notes indicated on 5/22/2011 at 11:00 a.m., "Res had inj [injury] fall this a.m." and was sent out to the emergency room. Review of nursing notes dated 5/22/2011 at 1:30 p.m. indicated the nurse called the emergency center to get an update on Resident #11 and was informed the resident was transferred to a higher level of care hospital with an unstable cervical spine fracture. Review of doctor's dictation notes dated 5/24/2011 indicated: "cervical spine x-rays revealed a C1 left fracture." Resident #11 was discharged from the hospital that day and went to an extended care facility for rehabilitation. Review of doctor's orders dated 7/8/2011			

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	indicated "re-admit to residential facility." Documentation was lacking to indicate a preadmission evaluation was done prior to re-admission related to a significant change in resident's condition. On 7/21/2011 at 8:10 a.m., the Administrator presented a copy of the facility's current policy on "Resident Evaluation". Review of this policy at this time included,but was not limited to:..."Procedure:...2. The Clinical Director/Director of Nursing...will complete a comprehensive pre-admission evaluation as soon as possible...9. Each resident will be evaluated at minimum semi-annually and upon a known substantial change in resident's condition, or more often at the resident's or facility's request..."			
R0216	(c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.			

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	Based on record review, observation and interview, the facility failed to ensure an evaluation of self medication was done for 1 of 1 resident (#2) in a sample of 7 residents and 1 of 1 resident (#11) in a supplemental sample of 19 residents reviewed for self administration of medications. Findings include: 1. On 7/18/2011 at 9:00 a.m., review of Resident #2's record indicated diagnoses including, but not limited to, dementia, hypertension, chronic obstructive pulmonary disease and failure to thrive. Documentation is lacking to indicate a self administration of medication assessment had been given. On 7/18/2011 at 9:30 a.m., during observation in Resident #2's room, over the counter medications were sitting on a counter in the kitchen area. Medications included vitamin C 500 mg in a 2/3 full bottle, Miralax [a laxative] 17.9 bottle 3/4s full, Tylenol arthritis 650 mg 3/4 full bottle, and vitamin D - 43 pills in bottle. On 7/18/2011 at 12:00 p.m. in an interview with the Director of Nursing (DON), she indicated that medications should not be in a room of a resident that	R0216	It is the practice of this facility to ensure evaluations of self medication administration are completed timely. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. *A self medication assessment was completed on Resident #2 and placed in chart. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. *A environmental audit was completed of all resident rooms to ensure there were no medications located in those resident rooms on those who do not self-medicate. *An audit was completed by the Clinical Director to include the charts of the residents who do self-medicate to ensure there was an up to date assessment of self-medication administration. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur. *The Nursing staff will be inserviced as to the facility policy and state regulations on completing self-medication assessments timely. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place *The Clinical Director will audit, monthly, the	08/21/2011

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	does not self medicate. 2. On 7/19/2011 at 11:02 a.m. review of Resident #11's record indicated diagnoses including, but was not limited to, hypertension and macular degeneration. Documentation was lacking to indicate a self administration of medication assessment had been done. On 7/20/2011 at 9:50 a.m., it was observed that the resident had the prescription medication fluticasone nasal spray on the counter in the resident's room. On 7/20/2011 at 1:25 p.m. review of the facility's current "SELF ADMINISTRATION OF MEDICATIONS" policy and procedure indicated; but was not limited to, "...Procedure 3. The nurse at the community/facility must also evaluate each resident who self-administers his or her medication by completing the 'Self-Administration of Medication Assessment' form."		charts of the residents who do self-medicate to ensure there is an up to date assessment of self-medication administration.	
R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.			

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	Based on record review and interview, the facility failed to ensure insulin administration records were complete to indicate the medication had been given for 1 of 1 resident reviewed for insulin injections in a sample of 7 residents. (Resident #10) Finding includes: Review of the clinical record for Resident #10 on 7/19/11 at 9:47 a.m., indicated the resident had diagnoses which included, but were not limited to, syncope and type II diabetes mellitus. On 4/11/2011, the physician gave an order for the resident to receive Lantus [insulin] - inject 10 units sub - q [under the skin] daily at bedtime. Review of the May and June 2011 Diabetic Flow Records indicated blanks on the following days to indicate the medication had been given: - May: 5/1, 5/2, 5/3, 5/4, 5/5, 5/6, 5/9, 5/10, 5/11, 5/12, 5/13, 5/14, 5/15, 5/16, 5/17, 5/18, 5/19, 5/20, 5/21, 5/22, 5/23, 5/24, 5/25, 5/26, 5/27, 5/28, 5/29, 5/30, and 5/31. - June: 6/2, 6/3, 6/4, 6/5, 6/6, 6/7, 6/8, 6/10, 6/11, 6/12, 6/13, 6/16, 6/17, 6/18, 6/19, 6/20, 6/21, 6/23, 6/24, 6/25, 6/26, 6/29, and 6/30.	R0349	It is the practice of this facility to ensure insulin administration records are completed to indicate the medication has been given. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **All Nurses and QMA's will be inserviced by 8-21-11 regarding the facilities policy ensuring all insulin medication administration records are completed to indicate the medication was given. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. **The Clinical Director audited the MARS to ensure all nurses and QMA's were initialing medication administration records, ensuring the medications were given. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur. **All Nurses and QMA's will be inserviced by 8-21-11 regarding the facilities policy ensuring all insulin medication administration records are completed to indicate the medication was given. **The Clinical Director will audit the MARS monthly to ensure the nursing staff is initialing the medication administration records indicating the medication has been given. How the corrective action(s) will be monitored to ensure the deficient practice will	08/21/2011

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	When shown the Diabetic Flow records during the daily exit meeting with the Administrator and the Clinical Director on 7/20/2011 at 1:30 p.m., they indicated they were very surprised with all the blanks and that it did not make sense. The Clinical Director indicated this was the new form they were using to track all the treatment/medications the diabetic residents received and where the insulin should have been documented as having been given.		not recur, i.e., what quality assurance program will be put into place **The Clinical Director will audit the MARS monthly, and ongoing, to ensure the nursing staff is initialing the medication administration records indicating the medication has been given.	
R0352	(e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided. (4) Progress notes. Based on record review and interviews, the facility failed to ensure physical therapy evaluations were completed according to physician orders for 1 of 1 resident in a sample of 7 residents and 1 of 19 residents in a supplemental sample of 19 residents reviewed for therapy. (Residents #4 and #13) Findings include: 1. Review of the clinical record for	R0352	It is the practice of this facilty to ensure physical therapy evaluations are completed according to physician orders. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **Resident #13 and her family, declined the physical therapy evaluation. It has been noted in her chart. **Resident #4 had a physical therapy evaluation done on 6-24-11. How will you identify other residents having the potential to be affected by the	08/21/2011

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	Resident #4 on 7/19/2011 at 10:50 a.m., indicated the resident was re-admitted to the facility on 6/16/2011 and had diagnoses which included, but were not limited to, seizures and chronic back pain. On 4/29/2011, a new physician's order for "Eval [evaluation] by PT [physical therapy]" was noted due to weakness. Documentation was lacking of the evaluation having been completed. During an interview with the Clinical Director on 7/20/2011 at 12:45 p.m., she indicated she had contacted the home health agency who was providing services to the resident and they indicated they had no record of an order for a physical therapy evaluation. She further indicated the evaluation was never done and did not know if it was on the facility's end or the home health agency that the evaluation had not been done. 2. Review of the clinical record for Resident #13 on 7/19/2011 at 2:00 p.m., indicated the resident had diagnoses which included, but were not limited to, dementia and osteoporosis. On 5/24/2011, the Hospice physician wrote an order for "PT eval for use of walker, gait training, balance and strength." Documentation was lacking of		same deficient practice and what corrective action will be taken. **The Clinical Director audited all residents charts to ensure physical therapy evaluations were completed according to physican orders. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur. **Nursing staff will be inserviced on ensuring physical therapy evaluations are completed according to physician orders. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place **The Clinical Director will audit, monthly, and ongoing, all orders received for physical therapy to ensure they have been carried out according to physician orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/21/2011

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	the evaluation having been completed. During an interview with the Clinical Director on 7/20/2011 at 12:45 p.m., she indicated "the resident's family did not want anything done so no PT eval was completed."			
R0414	(k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, record review and interview, the facility failed to ensure the infection control protocol, related to handwashing, was followed during 2 of 3 medication pass observations. This deficient practice affected 4 of 5 residents observed. (Residents #2, 17, 18 and 19) Findings included: On 7/18/2011 at 9:40 a.m. Qualified Medication Aide (Q.M.A) #1 was observed to prepare medications and administer four oral medications to Resident #2. Hand washing or use of antibacterial hand gel was not observed during the preparation, administration or after resident contact. On 7/18/2011 at 9:50 a.m. QMA #1 was observed to prepare medication and administer nine oral medications to Resident #17. Hand washing or use of	R0414	It is the practice of this facility to ensure infection control protocol, related to handwashing, is followed during medication administration. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. **LPN #1 and QMA #1 were inserviced on the facilities policy on infection control related to handwashing during medication administration. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. **After LPN #1 and QMA #1 were inserviced, the Clinical Director observed several of their medication passes to assure the they followed infection control protocol related to handwashing. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur. **The	08/21/2011

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	antibacterial hand gel was not observed during the preparation or administration. On 7/19/2011 at 8:30 a.m. Licensed Practical Nurse (L.P.N.) #1 was observed to prepare medications and administered two inhalation medications to Resident #18. L.P.N. #1 then donned gloves and proceeded to administer eye drops bilaterally to residents eyes. Hand washing or use of antibacterial hand gel was not observed during the preparation, administration or after resident contact. On 7/19/2011 at 8:45 a.m. L.P.N. #1 was observed to prepare medication and administer seven oral medications to Resident #19. Hand washing or use of antibacterial hand gel was not observed during the preparation, administration or after resident contact. On 7/20/2011 at 8:10 a.m. record review of facility's "ALL STAFF IN-SERVICE SIGN IN SHEET" indicated that on 1/13/2011 staff were in-serviced which included; but was not limited to, infection control and handwashing. Record review of page 3 of 11 of the in-service content indicated; but was not limited to, "Wash hands before and after all client or body fluid contact." On 7/21/2011 at 9:20 a.m. in an interview		Clinical Director will audit a medication pass each month, on each shift , ongoing, to assure the nursing staff is following infection control protocol related to handwashing. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place **The Clinical Director will audit a medication pass each month, on each shift, ongoing, to assure the nursing staff is following infection control protocol related to handwashing.	

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	with L.P.N. #1 she indicated that she washes hands after every 2 residents. On 7/21/2011 at 9:20 a.m. in an interview with Q.M.A #1 she indicated that she uses alcohol gel between each resident and washes hands every third resident.			